Family Practice Forum

Family Medicine and the National Health Service Corps

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The National Health Service Corps (NHSC) has emerged as the foundation of the federal strategy to improve the provision of medical care to underserved populations. The NHSC was created by Congress in 1970 to "improve the delivery of health services . . . where health personnel and services are inadequate to meet the health needs of the residents of such communities and areas."[1] The program, after a halting start, has grown rapidly. In fiscal year 1980, the combined NHSC scholarship and service appropriation is $165 million, a financial commitment which has grown exponentially since the $3 million with which the program was launched nine years ago.

Passage of new health manpower legislation in 1976 adding a prominent scholarship component to the NHSC program accelerated this growth. For each of the last two years approximately 3,000 medical students have accepted NHSC scholarships; the majority of these recipients are first year students, and most will be deferred in order to complete primary care residencies prior to service. This creates a large and growing pipeline of students traversing the educational system with an ultimate obligation to spend up to four years with the NHSC (Madison D, Shenkin S: Leadership for Community-Responsive Practice: Preparing Physicians to Serve the Underserved, unpublished. Robert Wood Johnson Rural Practice Project, Chapel Hill, NC, May 1978).

This major investment in medical students has significant implications for medical education in general, and family medicine in particular. Both the creation of the NHSC and the renaissance of family medicine emerged from the perception that something was seriously amiss in the American health care delivery system. The ambivalence of the traditional public health apparatus toward the implementation of the NHSC had a parallel in the resistance of the medical education establishment to the creation of family medicine as an academic discipline. In both instances, it is the patients and communities who benefit from these new physicians who have provided crucial political support, largely through the translation of their enthusiasm into effective state and federal legislation. Thus, the NHSC and the field of family medicine are a parallel manifestation of a common realization that the post-Flexnerian medical system in the United States—despite its glittering technological sophistication—has not been responsive to the need of people for accessible, affordable, compassionate personal medical care.

The expansion of the NHSC into the medical classroom increases the complexity of what has been a fairly simple program, and exposes it to significant dangers. To date, the majority of Corps assignees have been volunteers, choosing to join the NHSC as a vehicle to accomplish a diverse set of career goals. A significant percentage of these volunteers have elected to remain in their NHSC communities beyond their initial two-year com-

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mitments, and in certain favorable economic and professional settings, a number of the physicians have entered the mainstream of the private practice of medicine in these communities. With the introduction of the scholarship program, the complexion of the program has changed significantly; next year the majority of the assignees will be physicians performing obligated service in return for the scholarships that they received as medical students. The major danger that confronts the program is that this group will be ill prepared and alienated from the program that employs them and the communities they serve. Institutional medicine can be stultifying, and if this cohort of obligated physicians does not share the ideals and enthusiasm of their predecessors, the experience for community and physician alike could be dismal.

By the same token, the program presents an opportunity to increase the awareness and skills of medical students in the care of diverse populations in disparate settings. It provides an opportunity to channel the altruism which motivates many students to enter the field of medicine into practical and concrete applications in communities of need. It can catalyze the application of those principles of community medicine which are an essential component of family practice. And, it may serve as a vehicle to forge a creative collaboration between medical educational establishments and the federal government in bringing services to underserved people, a collaboration that is often lacking as health policy is developed and implemented.

Some initial cooperative efforts have begun. A number of medical schools around the country, usually through departments of family medicine, have provided continuing education, referral and consultation support, and outreach to NHSC assignees practicing in their areas. Experimental courses have been launched that send scholarship students to NHSC sites in structured preceptorships organized by departments of family medicine. And numerous residency programs have worked with communities designated for NHSC assistance, helping plan practices and recruit physicians, and assisting in the clinical support of the physicians who staff these sites. During the last year, the Society of Teachers of Family Medicine participated in a nationwide consortium to provide orientation and in-service training to field assignees, an effort that is continuing.

These efforts have not been sufficient. The future of the NHSC is troubled; the federal government, by its very nature, is too ponderous and politically vulnerable to be able to handle a program of this size and complexity without substantial assistance from other sources. When the program was a minor demonstration project buried in the bureaucracy it was possible to insulate the projects and the assignees from some of the obligate inanities that plague federal efforts in health. As the program grows in size, it is adopted by a diverse set of legislators, administrators, and constituent groups, each with its own perception of the program's mission. In the process of shaping the program to fit at times mutually exclusive agendas, it is twisted into a pretzel. Unfortunately, the result can be physicians who are soured by the experience, and communities whose already pressing health care problems are exacerbated by insensitive administrators or disgruntled physicians.

Family medicine has a stake in making the program work; to the degree that we are able to demonstrate that well-trained committed family physicians are part of the answer to the equitable and efficient distribution of health care, we will garner additional federal and state support. If the NHSC founders, the federal recourse will be to further centralize and rigidify the delivery system.

We have an opportunity to help shape the program by paying attention to those students who elect NHSC scholarships as a vehicle for financing their medical educations. By working with these students as they go through medical school and residency, we can equip them for their future roles and maintain their enthusiasm and interest. At the same time we should become educated with regard to the administration and focus of the program to ensure that it is not destroyed by inadequate funding, excessive rigidity, or inappropriate expectations.

Reference

1. US Congress, Emergency Health Personnel Act of 1970 (December 31, 1970), p 1